Appalachian Orthodontics of Lynchburg
Dr. Elena Black

SleepWellness Associates of Lynchburg
Elena Black, DDS, PhD

Patient Information

TODAY'S DATE _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ SSN: _____

Nickname: _____ Birthdate: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

School: _____ Grade: _____

Self: Occupation/Employer: _____

Firm or School: _____ Telephone: _____

Spouse Name: _____ Occupation: _____

Firm or School: _____ Telephone: _____

FINANCIAL RESPONSIBILITY

Individual Responsible For This Account: _____ Relationship To Patient: _____

Address: _____ City: _____ Zip Code: _____

Best Number To Be Reached At: _____ Birthdate: ____/____/____

DENTAL INSURANCE

Do you have dental insurance or medical assistance? ○ Yes ○ No

Primary Insurance Company: _____

Primary Insured: Last Name: _____ First Name: _____ SSN: _____

Address: _____ City: _____ Zip Code: _____

Occupation/Employer: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Birthdate: ____/____/____

Secondary Insurance Company: _____

Secondary Insured: Last Name: _____ First Name: _____ SSN: _____

Address: _____ City: _____ Zip Code: _____

Occupation/Employer: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Birthdate: ____/____/____

Initials: _____

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DENTAL HISTORY

Explain the nature of the problem in your own terms. Why do you think you may benefit from orthodontic treatment?

_____

_____

Whom may we thank for referring you to our office?

_____

Who suggested you might benefit from orthodontic treatment?

◯ Your Dentist ◯ A Family Member ◯ A Friend ◯ The School ◯ Other

Were you aware of any orthodontic problems prior to the referral? _____

Have you ever had orthodontic treatment? ◯ Yes ◯ No If so, when? _____

_____

_____

Name of your dentist _____

Last visit to dentist was on _____ for _____

Dentist's Address _____

_____

Do you grind or clench your teeth? ◯ Yes ◯ No

Does your jaw "click, crack or pop" upon opening or closing? ◯ Yes ◯ No

Do you have pain in the lower jaw upon opening or closing? ◯ Yes ◯ No

Do you have TMJ dysfunction? ◯ Yes ◯ No

Have you ever had any speech problems or any speech therapy? ◯ Yes ◯ No

Have you had any medical problems associated with dental treatment before? ◯ Yes ◯ No

Have you ever had any trauma to your mouth/teeth/face? ◯ Yes ◯ No

Do you primarily breathe through your mouth? ◯ Yes ◯ No

Do you snore? ◯ Yes ◯ No

Do your brush your teeth daily? ◯ Yes ◯ No

Do you floss daily? ◯ Yes ◯ No

Does the patient's physician recommend medication for a preexisting condition before any dental procedure? ◯ Yes ◯ No

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Medical Questionnaire

Patient's Physician: _____

Address: _____

Patient's general health: ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Please list any and all previous illnesses, hospitalizations or serious medical conditions: _____

_____

Please list any **allergies**:

_____

Are you currently taking any medications (pills, drugs, injections, etc.)? Please list them here:

_____

Has the patient ever taken intravenous bisphosphonates such as: Zometa, Aredia or Didronel? ◯ Yes ◯ No

Has the patient ever taken oral bisphosphonates such as: Fosamax, Actonel, Boniva, Skelid or Didronel? ◯ Yes ◯ No

Has the patient ever taken other bone antiresorptive medication? ◯ Yes ◯ No If yes, check all that apply:

◯ Denosumab (Prolia®) ◯ Calcitonin (Miacalcin®, Fortical®) ◯ Teriparatide (Forteo) ◯ Raloxifene (Evista®)

If female, are you pregnant or is there any possibility that you might be pregnant? ◯ Yes ◯ No

Do you presently have or have you **ever had** any of the following?

Anemia	◯ Yes ◯ No	Epilepsy/Seizures/Fainting spells	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Artificial bone/joints	◯ Yes ◯ No	Gonorrhea	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Adenoids/Tonsils removed	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Pneumonia	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Heart Disease	◯ Yes ◯ No	Psychiatric/Learning Disability	◯ Yes ◯ No
AIDS or HIV+	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Blood Disorders	◯ Yes ◯ No	Hemophilia/ Abnormal Bleeding	◯ Yes ◯ No	Sinus/Breathing Problems	◯ Yes ◯ No
High/Low Blood Pressure	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Cancer/Chemotherapy/Radiation	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Syphilis	◯ Yes ◯ No
Cold Sores	◯ Yes ◯ No	Hives	◯ Yes ◯ No	Tuberculosis/TB	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Jaundice	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
				Other _____	

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EPWORTH SLEEPINESS SCALE: how likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W Johns, Sleep 1991)

0 = would never doze I 1 = slight chance of dozing I 2 = moderate chance of dozing I 3 = high chance of dozing

Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive, in a public place (theater, meeting, etc.)	0	1	2	3
As a passenger in a car for an hour without break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Epworth Score
TOTAL the values from all 8 questions.
If 11 or less Score= 0
If 12 or more Score= 2

HABITS	Never	Rarely 0-1 times/wk	Sometimes 1-2 times/wk	Frequently 3-4 times/wk	Always 5-7 times/wk
On average in the past month, how often have you snored or been told that you snore?	❑ +0	❑ +1	❑ +2	❑ +3	❑ +4
Do you wake up choking or gasping?	❑ +0	❑ +1	❑ +2	❑ +3	❑ +4
Have you ever been told that you stop breathing in your sleep or wake up choking or gasping?	❑ +0	❑ +1	❑ +2	❑ +3	❑ +4
Do you have problems keeping your legs still at night or need to move them to feel comfortable?	❑ +0	❑ +0	❑ +0	❑ +0	❑ +4

Habits Score
TOTAL the values from all answers from first 3 habits

AUTHORIZATIONS

I authorize the release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

I certify that the above information is accurate and understand that an appropriate credit bureau report may be obtained.

I have read the above questions and understand them. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form.

I will notify my orthodontist of any changes in my medical or dental history.

Signature: _____ Date: _____